

Appendix E: Analysis of Quality Assurance Plans - Corporations Other Than HMOs

Methodology

In order to make comparisons about the quality assurance plans in HMOs and other corporations, a sample of corporations with indemnity plans was generated by the Bureau of Insurance, State Corporation Commission. A total of twenty-one (21) companies, representing the highest volume of policies, were chosen. Each company CEO was faxed a letter from Randolph Gordon, Commissioner of Health, asking for their participation in this study and requesting contact information. This information was compiled by the Virginia Department of Health and forwarded to the Department of Health Evaluation Sciences at the University of Virginia. Contact information was received for fifteen (15) companies.

As was done with the HMOs, a research assistant initiated contact with the people deemed most responsible for QA plans at each plan. In some cases, the research assistant was referred to other employees of the plan. Once the correct person was reached, the research assistant explained the purpose of the study and outlined the requirements of participation. When consent was obtained, the research assistant faxed the lists of questions relating to the quality assurance plans. Each plan was instructed to complete the questions with relevant citations noted and to send current QA plans to DHES. They were requested to complete these tasks within 5 working days, and report back if they could not meet this deadline. Follow-up phone calls were utilized as reminders to those plans that did not respond within this time frame.

Questions for the study were provided by the Virginia Department of Health in consultation with the HB 2785 Study Group. All questions were sent to all potential participants in the study. Specific references to HMOs were stricken from the sets of questions sent to non-HMO companies.

The following companies were contacted regarding their QA plans: Prudential, Mutual of Omaha, Employees Health Insurance, Trigon Blue Cross Blue Shield, AFLAC, The Guardian, Mass Mutual, UNUM, Principal Mutual Life, Portis, New York Life, State Farm Mutual Auto, Continental Assurance Company, Aetna, and Combined Insurance Company. Full responses were received from Mutual of Omaha, Employees Health Insurance, and Trigon. State Farm Mutual Auto, AFLAC, UNUM, and Combined Insurance Company reported that they do not have any managed care products and therefore did not have quality assurance plans or grievance procedures as defined in this study. Mass Mutual was dropped from the study because it had been sold twice and no appropriate person could be contacted during the study period. A tracking chart listing the plans and the status of their submissions follows the analysis of the grievance plans in Appendix F.

Once the documentation and completed questionnaires were received at DHES, the

researchers examined the answers and citations for completeness, accuracy, and clarity. Any questions were referred back to the individual plans. In addition, DHES interviewed appropriate personnel in order to supplement the information provided by the answers to the questions.

Analysis

Three non-HMO plans responded to our questions. Each question in the analytical framework has been answered using responses from all three plans, followed by comments from the researchers in some cases. In some cases, the answers to the questions were not explicitly stated in the grievance procedures for each plan. This has been noted where appropriate.

ANALYTICAL FRAMEWORK FOR EXAMINATION OF INDEMNITY (non-HMO) QUALITY ASSURANCE PLANS

1. Prevention

- a. Identify the QA plan's goals and objectives that address preventive care. Name, if applicable, specific HEDIS measures that will be undertaken (e.g. cholesterol screening, diabetic retinopathy exam, mammography recommendation, etc.). If HEDIS measures are planned, describe what efforts the plan is making to ensure valid and reliable encounter data.

One plan gave a very detailed answer to the study question, but these activities were not documented in their QA plan. They mentioned using HEDIS measures, but did not specify which. Two plans stated that they don't use HEDIS measures, but they do have other programs in place to address preventive care. This process was well-documented in one plan's QA plan, but not mentioned in the other.

Comments: Many PPO plans do not try for NCQA accreditation, so many companies with these plans do not implement HEDIS measurements.

- b. Are prevention guidelines developed by the company or does the plan make reference to national practice guidelines? How?

One plan does not currently have prevention or practice guidelines, but they have participated in NCQA's Report Card Pilot Project to help determine levels of preventive care received by their members. One plan utilized the HCFA Case Management Program as the base in the internal development of practice guidelines. Reference to this was not found in the QA plan. One plan endorses national prevention and practice guidelines which are customized for regional practice variation. This process and specific references were not described in the QA plan.

- c. Are there indications in the plan that guidelines for preventive care are shared with providers

or that provider input was solicited?

One plan has shared the results of formal studies with appropriate providers, but this was not documented in the QA plan. One plan has involved several providers in a pilot prevention project, but this was not in their QA plan. Guidelines for one plan were developed using advisory panels, and they are distributed to all providers through a newsletter; this was documented in the QA plan.

2. Complaint Resolution

- a. What provisions does the plan make for aggregation and analysis of complaints and grievances?

One plan tracks and analyzes all complaints and reports statistics quarterly. One plan has an online system for tracking. One plan uses a large database to record all complaints for later analysis. This information was found in all three QA plans.

- b. What is the physician's office told with respect to appealing a denial for service? Are they given the name and number of the medical director? Is there a physician/provider helpline?

One plan notifies the physician in case of a denial, and the physician is allowed to appeal. In this case, the physician reviewer contacts the involved physician personally. They use their regular customer service department for standard questions, but there is a separate number for physicians involved in appeals. The process was mentioned in the QA plan, but not in detail.

One plan has a special department that helps physicians. The name of the medical director is given to the physician at the time they are informed of the denial. The process is well-documented in the QA plan.

One plan uses their standard appeals process that does not make specific reference to providers.

- c. What provisions does the plan make for systematic follow-up and corrective action on identified problems?

All three plans have guidelines for follow-up of problems that depend on the type of problem. This was not stated explicitly in any of the QA plans. Their tracking systems allow them to analyze trends.

3. Access and Availability

- a. What activities does the plan describe for monitoring access and availability?

One plan uses a computer program to track network access on a quarterly basis; standards vary depending on population density. One plan answered this question in relation to availability of staff at the plan, not providers; they maintain open hotlines 24 hours per day/7 days per week.

No staffing ratios were noted in their QA plan. One plan reported that this question was not applicable to them.

- b. What are the standards for appointment availability for routine, urgent, and emergency care?

One plan put standards at 1 to 3 days for routine care, within 24 hours for urgent care, and immediately for emergency care. This was not documented in the QA plan. One plan does not monitor waiting times or time to appointment, but does track complaints about this topic. One plan reported that this question was not applicable to them.

Comments: Again, regulations about access to care are not applicable to non-HMOs, so many plans do not have standards. This doesn't necessarily mean they have long waiting times, but there is currently no mechanism to police this issue.

- c. What are the standards regarding primary care physicians access (e.g. ratio of PCPs to members; travel times; closed panels)? Does the plan offer any incentives to PCPs to keep their panels open to new members? Are there any other incentives to improve access?

One plan does not maintain a PCP to member ratio for their program or monitor the number of physicians who are accepting new patients. They do not offer incentives. One plan has access standards that range from 5 in 5 miles to 2 in 30 miles, depending on geographic area and population density. They also strive to keep 97% of their practices open. These standards were not documented in their QI plans. One plan reported that this question was not applicable to them.

- d. Is the formulary binding or advisory?

One plan reported that their formulary was advisory. Two plans stated this question was not applicable.

- e. Which pre-certification requests CANNOT be done on the phone, but require medical record review?

One plan requires that all requests for medical rehabilitation services must include medical record review. Also, records are required for retrospective review. One plan allows all pre-certification requests to be done on the phone, but additional information may be required in some cases. For one plan, medical record review is required for certain procedures, such as transplants and cosmetic surgery, and may be required for other surgical procedures; each case is handled on its own merits. This was detailed in one company's QA plan.

- f. How is PCP bonus or withhold affected when a patient exercises his POS option vs. when the referral is to an in-network provider?

One plan separated member self-referral outside the network, which does not affect PCP bonus, and provider referral outside the network, which does negatively affect the bonus. One plan stated that this does not affect PCP bonus, which is based on quality and utilization. One plan reported that this question was not applicable to them.

- g. Does the plan have standards for response time to providers requesting preauthorization for services? Is there a plan for improved response times?

One plan stated that response time is within one business day of receiving all information. They also reported that they have no system for improving response times because most preauthorizations are done immediately. This was documented in the QA plan. Two plans did not include this information in their QA plans. One of these plans has a standard of completing all requests within 48 hours; they monitor this standard on a monthly basis and use the results to investigate problems. The other plan stated that their standard is 24 hours, and they currently meet this standard based on their reviews.

- h. Are physicians at risk for more than services provided in their offices through use of either of the following reimbursement models?

Global Capitation: “a type of reimbursement in which an entity such as a physician-hospital organization is reimbursed a capitation amount for a particular group of members, and such entity is responsible for providing or paying for all (or most) of the covered services provided to those members by any provider.”

Episode of Care reimbursement: “A provider is paid a fixed dollar amount for the treatment of a specific illness, condition, surgery or episode of care. The provider is responsible for using this fixed payment to cover all expenses related to such illness, condition, surgery, or episode of care. For example, a surgical group would be responsible for using this fee to cover the hip joint surgery and related expenses such as anesthesia, radiology, hospitalization, etc.”

This was not applicable for two of the plans. One plan does not use global capitation, but they are working on a pilot program for joint replacements under episode of care reimbursement.

- i. What specialties are paid by capitation?

This was not applicable for any of the plans.

4. Credentialing

- a. What credentialing activities are identified in the plan?

All three plans gave detailed answers that include numerous application requirements, but

documentation was found in only two QA plans.

- b. What credentialing activities are done in the interim between recredentialing?

One plan conducts annual reviews of all credentialing criteria. One plan monitors provider complaint and grievance patterns and takes corrective action if needed. One plan also performs ongoing medical record review and quality indicators reviews. One plan described these activities in their QA plan; the other two did not.

- c. How is the plan informed of providers whose licenses are revoked or suspended?

One plan tracks their providers on a monthly basis and sends this information to employers, but not to all enrollees. One plan relies on the State Boards of Medicine, and one plan employs an outside service that provides updates on these matters. None of the plans mentioned this process in their QA plans.

5. Consumer Satisfaction

- a. What activities does the plan describe to assess consumer satisfaction?

One plan sends out weekly patient and provider satisfaction surveys. This is not in their QA plan. Two plans send out consumer satisfaction surveys for their POS plans only, and this is documented in their QA plans.

- b. If a survey is undertaken, what does the plan do to ensure scientific validity and reliability of the instrument?

Two plans use an instrument that is developed internally by a survey expert. One plan uses the NCQA survey for its POS products and an outside vendor for surveys for other indemnity products offered by the company.

- c. What activities are identified by the plan that address UR denial and appeals?

One plan publishes a quarterly report with summary UR decisions by group. The other two plans have detailed UR plans that include systematic tracking of UR decisions. All three plans had this information in their QA plans.

- d. Does the plan comply with Virginia Code §38.2-4304.B? (“The governing body [of the plan] shall establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (I) the establishment of advisory panels, (II) the use of advisory referenda on major policy decisions, or (III) the use of other mechanisms.”)

One plan stated that this law does not apply to them. Two plans stated that they have

valid Virginia licenses and comply with all regulations that apply to them.

- e. Do members receive physician-specific performance information such as “report cards?”

All plans stated no.

- f. Are physician satisfaction surveys undertaken? If so, how are they conducted? What is done with the results?

Provider satisfaction surveys are not done in any of the three PPO plans, but satisfaction surveys are conducted in the POS plans that these three companies manage. Provider surveys with the plan are done weekly in one plan, but no surveys of satisfaction of patients with their providers are done. The results are kept internal. In the other two plans, members are surveyed about their satisfaction with their provider, and this information is reported back to the individual PCP.

- g. Does the provider relations department track provider complaints and concerns? How?

Two plans reported that there is a special group that tracks provider issues. One plan uses the regular customer services department but flags provider calls. This information was documented in two of the three QA plans.

6. Improvement of Community Health

- a. What focused studies are identified in the goals and objectives of the plan? (i.e., disease-specific, population-specific) Are methodologies identified?

One plan mentioned their study of asthma patients. One plan is also studying asthma and diabetes; this plan is currently expanding their disease management programs. One plan is doing a pilot study on patients with CHF to try to improve care. This information was not found in any of the QA plans.

- b. What provisions does the plan make for feedback to providers concerning QA activities in general and specific outcomes of care in particular?

All three plans have feedback mechanisms to their providers through their quality assurance departments. This was not documented in the QA plans.

7. Outcome Measures

What activities does the plan indicate will be initiated to address poor clinical outcomes such as death, readmission to the hospital, hospitalization following ambulatory surgery, unscheduled return to the O.R., post-op infections?

All three plans track poor clinical outcomes (readmissions after adverse decisions, ambulatory surgery, and outpatient provider visits; mortality), but none was detailed in the QA plans. One plan did describe a specific study about asthma admissions and readmissions and how this information is shared with providers.

Conclusions: QA plans for non-HMO companies are much less extensive than those of their HMO counterparts. This can be attributed to a number of things, including decreased regulation of non-HMO companies and lessened importance of outside accreditation such as that done by the NCQA.